For Members of the American Dental Hygienists' Association

DISABILITY INCOME INSURANCE APPLICATION

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Hartford, Connecticut 06155

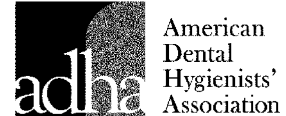
TO APPLY:

1. Complete and sign the application.

2. Send no money with your application. You will be billed upon approval.

3. Use the postage paid envelope provided to return to:

ADHA GROUP INSURANCE PROGRAM
P.O. Box 10374
Des Moines, IA 50306-8812



Section 1

Association Name: American Dental Hygienists' Association	Policy No.: AGP-5879	Certificate No.: (Leave Blank)

Section 2

Name: (First, Middle Initial, Last)	☐ Male ☐ Female	Height: ____ft. ____in. Weight: ______lb.	
Street:	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Age Last Birthday:	Place of Birth (State/Country):	
Daytime Phone No.: ( )	Business Telephone: ( )	Email Address:________________	
Occupation:		Pre-Disability Earnings: $__________	
Business Address: Street:			
City:		State:	Zip Code:

PA-9357 (HLA) (CA) (2-12)

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Section 3

Spouse/Domestic Partner's Name: (First, Middle Initial, Last), if applying	❑ Male ❑ Female	Height: ____ft. ____in. Weight: ____lb.	
Street:	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Age Last Birthday:	Place of Birth (State/Country):	
Spouse/Domestic Partner's Occupation:			
Daytime Phone No.: ( )	Business Telephone: ( )		
Pre-Disability Earnings: $__________________			
Business Address: Street:			
City:	State:	Zip Code:	

Section 4

COVERAGE REQUESTED:

Member Coverage:

❑ New Coverage: ❑ Plan II
Monthly Benefit Amount: $__________

❑ Change in Coverage:
Increase my Monthly Benefit Amount to: $ _______________

❑ Change in Elimination Period: ❑ 60 days ❑ 90 days ❑ 180 days

Spouse/Domestic Partner Coverage:

❑ New Coverage: ❑ Plan II
Monthly Benefit Amount: $__________

❑ Change in Coverage:
Increase my Monthly Benefit Amount to: $ _______________

❑ Change in Elimination Period: ❑ 60 days ❑ 90 days ❑ 180 days

Section 5

Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this or any other company? ❑ Yes ❑ No
If yes, give details:

Name	Company	Monthly Benefit	Benefit Period	Elimination Period	To be replaced?	
					Yes	No

Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation (at least 20 hours per week) 90 days before the date of this application? You: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

Is the Monthly Benefit Amount herein applied for equal to or less than 60% of your Pre-Disability Earnings minus any Other Income Benefits?
You: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

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Section 6

All questions are answered to the best of my knowledge and belief:		Member YES/NO	Spouse/ Domestic Partner YES/NO
1	In the past 10 years, has anyone proposed for coverage been diagnosed or treated by a member of the medical profession for:		
	A. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system?	❑ ❑	❑ ❑
	B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?	❑ ❑	❑ ❑
	C. Colitis, ulcer, kidney disease or disorder or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive system?	❑ ❑	❑ ❑
	D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?	❑ ❑	❑ ❑
	E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?	❑ ❑	❑ ❑
	F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?	❑ ❑	❑ ❑
	G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests?	❑ ❑	❑ ❑
2	During the past 5 years, has anyone proposed for coverage consulted any physician, surgeon, psychologist, psychiatrist or other practitioner for any reason not previously noted on this application; or been confined or treated in any hospital, sanatorium or similar institution?	❑ ❑	❑ ❑
3	Is anyone proposed for coverage now pregnant?	❑ ❑	❑ ❑
	If yes, Name: ______________________________		
	When is the baby due? ____________________		
	What was your pre-pregnancy weight? ______________		
	Are there any medical complications?	❑ ❑	❑ ❑

Section 7

If you answered "Yes" to any of the above medical questions, please explain the details below.			
Question Number and Condition	Name of Family Member	Dates	For any question answered "yes" please provide details, your physician's name, full address, and phone number (Required for processing)

(Attach sheet of paper if additional space is needed. Sign and date additional sheet of paper.)

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Section 8

AUTHORIZATION

I hereby certify that I have read or have had read to me all statements and answers in this application, and in any other application or medical form required by Hartford Life and Accident Insurance Company, and that they are full, complete, and true to the best of my knowledge and belief. I also understand that any misrepresentation contained herein or relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk. I understand that any intent to defraud or knowingly facilitate a fraud against the Company, by submitting an application or filing a claim containing a false or deceptive statement is insurance fraud. I also agree that a copy of this application shall be attached to and form a part of any certificate issued. I also understand that the Company may request whatever additional evidence of insurability it needs.

Subject to the deferred effective date provision, I understand that coverage will not become effective until the Company grants its underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium.

I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; Medical Information Bureau, Inc.; or employer; to give Hartford Life and Accident Insurance Company or its legal representative information about my physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage.

Hartford Life and Accident Insurance Company will use the information to decide if and to what extent I am eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I understand the Medical Information Bureau, Inc. will release records or information only to Hartford Life and Accident Insurance Company.

I authorize Hartford Life and Accident Insurance Company to give information about me to: its reinsurer(s), the Medical Information Bureau, Inc., any other insurance company to whom I may apply for Life or Health Insurance, or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application or as required by law.

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on the authorization. This authorization expires two (2) years from the effective date of my coverage or, if no coverage has been issued one (1) year from the date of this application.

I understand that a photocopy of this form is as valid as the original, and that I have a right to receive a copy of this form upon request.
I certify that I have received the Notice of Insurance Information Practices. I agree that this document and all of its contents shall form a part of my enrollment request for group benefits.

PRE-EXISTING CONDITIONS LIMITATION: I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12 month period prior to my effective date of coverage will not be covered until I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or until 24 months year after my effective date of coverage, whichever comes first, provided that the condition is not specifically excluded or limited by the policy or by a Health Waiver attached to my certificate. Applications to increase coverage will be subject to a new pre-existing conditions limitation. I further understand that any condition excluded or limited by the policy or by a Health Waiver attached to my certificate will not be covered under this policy at any time.

Notice: I understand that California law prohibits an HIV test from being required or used by Health Insurance Companies as a condition of obtaining health insurance coverage.

SECTION 9

I wish to pay my premiums: ❑ Automatic Monthly Check Withdrawal ❑ Semi-Annual Direct Bill
(If you select Automatic Monthly Check Withdrawal, please complete the Automatic Monthly Check Withdrawal Request.)

SECTION 10

Member's signature (Sign name in full) ____________________________ Date____________________________
Required Required

Spouse/Domestic Partner's signature (if applying) ______________________________ Date__________________________
Required Required

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

QUESTIONS?
Call: 1-800-503-9230
E-Mail: customerservice.service@mercer.com

PA-9357 (HLA) (CA) (2-12)

Disability Form Series includes GBD-1000, GBD-1200 or state equivalent.

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